

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28417**
Registrar's No. **4**

FILED SEP 5 1941
Registration District No. **346**

Primary Registration District No. **5-484**

1. PLACE OF DEATH:

(a) County **Harrison**
(b) City or town **Hatfield**
(c) Name of hospital or institution **Lumber Truss**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **20 yrs. 1** (Specify whether years, months or days)
In this community **20 yrs. 1**

3. (a) PRINT FULL NAME **WILLIE DEASON**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **MO** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Dec. 20 1870**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 5 16 hr. min.

9. Birthplace **Unknown** (City, town, or county) **Illinois** (State or foreign country)

10. Usual occupation **Lived with sister**

11. Industry or business _____

12. Name **Jessie Deason**

13. Birthplace **Unknown** (City, town, or county) (State or foreign country)

14. Maiden name **Margaret Thompson**

15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **John A. Deason**

(b) Address **Hatfield, Mo.**

17. (a) **Burial** (b) Date thereof **6-9-1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Hope Cem.**

18. (a) Signature of funeral director **John A. Deason**

(b) Address **Hatfield, Mo.**

19. (a) **7-10-41** (b) **Chas. Deason**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Harrison**
(c) City or town **Hatfield** (If outside city or town limits, write "RURAL")
(d) Street No. **Hatfield** (If rural, give location)
(e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6** day **6**
year **1941** hour **12** minute **45P** M.

21. I hereby certify that I attended the deceased from **6-6-1941** to **6-6-1941**
that I last saw him alive on **6-6-1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia**
Duration **few days**

Due to **✓**

Due to **✓**

Other conditions **✓** (Include pregnancy within 3 months of death)

Major findings: **✓**

Of operations _____

Of autopsy **✓**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **✓**

(b) Date of occurrence **✓**

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **✓**

While at work? **✓** (Specify type of place) (e) Means of injury **✓**

23. Signature **Chas. Deason** (M. D. or other)

Address **Hatfield, Mo.** Date signed **6-7-41**

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Arch C. Duffee

Licensed Embalmer No. *3252*

P. O. Address *Grant City, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.